Hawaii Dept. of Health, Office of Heal[illegible]Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. BUILDING: _____ B. WING _____ RECEIVED	12/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULANA MALAMA	91-1360 KARAYAN STREET EWA BEACH, HI 96706

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4 000	Initial Comments A state re-licensure survey was conducted from 12/19 - 12/29/17. At the time of entrance, the census included 20 pediatric residents and 5 adult residents.	4 000	It is the policy of Kulana Malama to follow all federal, state, and local guidelines, laws, regulations, and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission, and implementation of this plan of correction will serve as our credible allegation of compliance.	
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on record review, interviews and review of the facility's policies and procedures, the facility's governing body failed to ensure there was a clear process by which the administrator was informed and acted upon the problems affecting the overall operations of the facility. Finding includes: The cumulative findings of this survey are cross-referenced to this citation. During the interview of Staff #82 for the QA interview on 12/28/17 at 12:31 PM, there was no clear process by which she could demonstrate how often she reported to the governing body and in turn, how the governing body responded to on-going concerns. These should have included the quality of care and treatment of their residents, high medication error rates, policies and procedures last updated in 2012, insufficient daily staffing of licensed staff, and the lack of competency training for their staff, among other	4 088	It is the policy of Kulana Malama for the governing body to have an active role in supporting the Administrator and facility management. The Administrator will provide a monthly report to the governing body that includes identified quality issues, improvement efforts, and information on staffing, recruitment and retention. The governing body will make	

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/29/18

31.18-copy to VGM (on KM's behalf); bn | 2.16.18-copy scanned to self; bn

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4 088	Continued From page 1 findings. Staff #82's facility assessment given to the SA was also incomplete. On the morning of 12/27/17, the owner and as a member of the governing body, he stated he had not seen this facility's facility assessment.	4 088	recommendations based on the results of the reports provided to them. The governing body will receive information from the Administrator at least monthly that includes reportable events, serious injuries, serious medication errors, wounds, hours per patient day, agency staff numbers versus employees, and turnover. All residents have the potential to be affected by this practice. The Administrator or designee will be responsible for compliance.	2/12/18 & ongoing
4 091	11-94.1-17(1) Administrator All freestanding and hospital-based nursing facilities shall be administered by: (1) A person appointed by the governing body and responsible for the management of the facility; and (2) Licensed by the State as a nursing home administrator; or (3) In the absence of the administrator, an employee who has been designated, in writing, to act on the administrator's behalf for a determined period of time as approved by the department. This Statute is not met as evidenced by: Based on observations, record reviews, interviews and review of the facility's policies and procedures, the facility failed to be administered in a manner such for it to use its resources effectively and efficiently to ensure each resident is able to attain or maintain their highest practicable physical, mental and psychosocial well-being. Finding includes: The cumulative findings of this survey revealed that Staff #82 was aware of and ackowledged the systemic problems found during the survey. For	4 091	It is the policy of Kulana Malama to provide administration effectively and efficiently, using resources to attain or maintain the highest practicable physical,	

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4 091	Continued From page 2 one, the facility assessment was incomplete and Staff #82 stated on 12/22/17, it was going to their "QA" (quality assurance and performance improvement committee). However, she verified their QA committee has not met since July 2017. Yet, there were no emergency QA meetings noted, despite the fact their staffing patterns had changed, they lost their medical director, and that Staff #82 had to recruit a large number of agency nurses, most without deemed competency skills training revealed in this survey, in order for the facility to operate/care for all of its tracheostomy/ventilatory dependent residents. During the interview with Staff #119 on 12/22/17, she stated that Staff #82 and Staff #66 were aware of these problems but nothing was being done about it. Staff #119 stated she was asked to help Staff #66 learn the role of being the director of nursing (DON), although she has been a DON now for two years. Staff #119 also stated due to a lot of internal dissension with the former medical director and administrative staff, the outcome has been this procrastination and a loss of approximately 10-14 nurses leaving the facility in the past four to six weeks. On 12/28/17 at 3:56 PM, Staff #66 brought in a revised medication event report summary and said she was told by Staff 82 to put the tracking log together for January to May 2017. Although earlier she stated there was no tracking for January through May, she put together a report which included the entire year. Staff #66 verified that when she was asked about the medication errors identified on the report, she identified the number of event reports instead of the actual number of medication errors, although the number of errors were the critical values to focus on. On 12/28/17 at 5:00 PM, Staff #82 affirmed	4 091	mental, and psychosocial well-being for all residents. The facility assessment will be reviewed and revised to meet the regulatory requirements of F838. Education will be provided to management team on the required elements of the facility assessment. The governing body will be a part of the facility assessment process. All residents have the potential to be affected by this practice. The QAPI Committee had a meeting on 1/18/18 to discuss current 2567 and methods to correct deficient practices. The QAPI Committee will resume meetings at least quarterly. Staffing meetings will be held as needed to ensure the management team is implementing necessary efforts to focus on recruitment and retention of staff members. The governing body will approve the recruitment and retention efforts of the staffing committee. Medication error tracking and trending reports will be reviewed at least quarterly at the QAPI meetings and results shared with the governing body.	2/12/18 2/12/18 & ongoing

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4 091	Continued From page 3 they had to find a new tracking system and more training for Staff #66 to track the medication errors. Staff #82 also acknowledged the reports were only being developed once the SA began asking for them from the beginning of the survey and recognized there was no system in place. Staff #82 verified the policies and procedures had not been reviewed/revised by the end of the extended survey. Staff #82 stated, "No, in all honesty, no," as her response. She had been discussing it with their interim medical director and re-did the abuse type policy as well as creating a binder for the administrative policies. She confirmed the facility's existing policies and procedures have not been reviewed/revised for a long time. (Staff #66 had confirmed it was last done in 2012). Staff #82 also stated there was a loss of their regular licensed staff with the largest exit of staff "starting around 4-6 weeks ago." She said these were the nurses who were at the facility 7-9 years, and currently, there was almost no licensed staff with this many years of experience. She also stated their facility assessment "is going to the QA committee." On 12/28/17 at 12:31 PM, the initial payroll based jounal (PBJ) was given to the SA. During this interview with Staff #82, she stated acknowledged that based on the PBJ and the difference in staffing numbers, that this was a trend occurring from October 2017. Although aware of this, Staff #82 did not produce documentation of how this was being addressed with the governing body or with QA. Staff #82 also discussed the medication errors as reflected on their summary report compiled by Staff #66. Staff #82 said initially, people were saying it was the agency nurses with the	4 091	Policies and procedures for the facility will be reviewed and revised to ensure they meet the updated federal regulations and facility practices. The policies will be reviewed and approved by the Medical Director and QAPI Committee. The previous Medical Director has resigned and a new Interim Medical Director is in place while interviews for a permanent Medical Director are completed. A qualified nurse has been assigned as the Infection Preventionist. Education will be provided for the Infection Preventionist on the new and revised regulations for Infection Prevention and Control. Policies,	2/12/18 & ongoing 2/12/18 2/12/18 & ongoing

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4 091	Continued From page 4 medication errors and aware that double doses were being given. She said her goal was to get Staff #66 and Staff #119 to work together to develop their programs. She said they need to implement a system to make sure the errors were going down. She acknowledged they did not have the last QA meetings and said she was feeling upset as to why the medication errors were not completely accounted for. Staff #82 stated, "We have an ongoing problems with meds. We needed (Staff #119) to come in to help us with all the med errors and help us." However, there was no indication this was brought up to the governing body, if the QA meetings were not being held. Staff #82 also confirmed for the facility's policies and procedures and with Phase 2 of the long term care requirements, their policies "that are in place were pretty ancient, were not being updated. We have two different levels that we are going on. This was more on the administrative side. I have been going through them one by one trying to ensure that things were updated." She their policies and procedures have not been worked on since 2012. Staff #66 also confirmed this previously. With regard to the development of the facility assessment, Staff #82 stated because of their facility type as a long term care pediatric and adult ventilatory dependent resident facility, she was trying to figure out how to do the ICD codes, what the areas were to review, and that because they had the data, "taking the next step, such as do we need to look at the equipment." She stated she asked Staff #30 about helping her understand it. She stated their governing body is going to approve it at their January meeting, but they have to get the QA approval first. The SA	4 091	Audits will be completed on facility assessment, QAPI, staffing, medication errors, policy and procedure review and revision, and infection control practices, weekly for four weeks, monthly for three months, and then as needed to ensure compliance. The results will be reported to the QAPI Committee for further review and recommendations. The Administrator or designee will be responsible for compliance.	2/12/18 & ongoing 2/12/18 & ongoing

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4 091	Continued From page 5 informed Staff #82 their facility assessment is incomplete and stated there were no evaluations of their programs in place, they had not updated their policies, staff has not been fully trained, it did not include their resources at hand, competencies were not there, and the facility assessment was to have been completed prior to this survey. Staff #82 was also informed that during our meeting with the owner on the morning of 12/27/17, he stated he never saw the facility assessment report. Staff #82 also stated, "We don't have an active infection control (IC) committee." She stated the former medical director and their current IC consultant did not collaborate. She said the physician did not believe in obtaining lab cultures and was set in his ways, and was to have trained Staff #66, but that too did not occur as a result. She stated the IC consultant came to the facility around six months ago to work with Staff #66 instead, so "she has had six months." Staff #82 stated by 1:51 PM of this interview, that they should be using the new IC forms which were given to Staff #66 to use. For the PASARR finding, Staff #82 verified after the former medical director left, they were not done. Thus, based on the survey findings and interviews, observations of care and record reviews conducted, it was determined the overall lack of action by the administrator, governing body, medical director, and other administrative personnel, who were aware of their deficient practices, failed to demonstrate what corrective measures/ actions were undertaken and/or documented to show it was being done.	4 091	For R19, R20, R10 and R27 a Level 2 screen was completed. Education was provided for staff members on the proper completion and submission of both Level 1 and Level 2 preadmission screening documents. Other residents who may have MD and/or ID may have the potential to be affected by this practice. Audits will be completed on all residents to ensure correct screening has been completed and is accurate for all current residents and new admissions. Results will be reported to the QAPI Committee for further review and recommendations. The Director of Social Services or designee will be responsible for compliance.	1/30/18 1/24/18 2/12/18 & ongoing

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4 105	Continued From page 6	4 105		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the medical records were accurately documented for 2 of 16 residents (Residents #1 and #3) in the survey sample. Findings includes: 1. On 12/27/17 at 12:19 PM, Staff #98 verified she made a recordation error by omitting the 12/21/17 vital signs she took on the CNA log sheet for Res #1. She said it is the aide's responsibility to log the vitals. Staff #15 said they put the Bair Hugger on the resident if his temperature went below 96 degrees F, and, "If his heart rate is low, that means he is cold. Or I'll try and keep his head warm."	4 105		

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4 105	Continued From page 7 Interview with Staff #66 found she concurred that the current vital signs log was inconsistent with missing information. This was information that should be included as interventions to implement into Res #1's care plan. Staff #66 said she was responsible for this as well as the licensed staff. 2. Resident #3 was observed on 12/19/17 at 11:25 AM to have a small quarter sized bruise like spot in the inner aspect of his right forearm during his range of motion exercise while in the 60 degree standing position. Staff #103 was there assisting the resident with his activities. On 12/21/17 at 11:12 AM, Staff #88 showed Res #3's right forearm and said it looks like a small rash. but Staff #103, said she saw it on 12/19/17 and it looked like a bruise. Staff #103 said it "looks like rash" and then Staff #12 came over to do an assessment of it. Record review on 12/22/17 found Staff #12's progress note (shift report) date was incorrect. Staff #110 confirmed this. Staff #12 wrote 12/20/17 but it should have been 12/21/17. There also was no documentation of Res #3's skin condition although Staff #103 was observed looking at it and saying it looked like a rash. There were no new orders as well. On the 24 hour charge nurse report, there also was no documentation of it by Staff #12, although Staff #110 said it should be there.	4 105	For R1 the vital sign log will be completed as required per policy and procedure. Education will be provided to the staff on proper documentation of vital signs. Other residents who have orders for vital sign checks have the potential to be affected by this practice. For R3 an assessment was completed to determine the etiology of the skin discoloration. It was determined to be a rash. The documentation was updated to reflect the resident's current skin condition. A treatment for the rash will be implemented if ordered by the physician. Education will be provided for staff members on documentation accuracy. Other residents who have skin alterations have the potential to be affected by this practice. Audits will be completed on nursing documentation weekly for four weeks, monthly for three months, and as needed with results reported to the QAPI Committee. Recommendations will be implemented if the QAPI Committee deems it necessary. The Director of Nursing will be responsible for compliance.	12/29/17 12/29/17 2/12/18 & ongoing
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family,	4 115		

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4 115	Continued From page 8 legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure each resident received care with dignity in a manner that promotes or enhances his or her quality of life for 4 of 16 residents (Residents #7, #14, #18 and #25) in the survey sample. Findings include: 1) Observation of Resident #7 (Res #7) revealed staff failed to care for him such as to maintain or enhance his quality of life, as this resident is unable to make his requests for assistance known. On 12/20/17 at 12:29 PM , Res #7 was observed laying in his bed connected to the ventilator. He had a large amount of saliva and drool that was bubbling and coming out of his mouth, down and under his chin and pooling by his tracheostomy (trach) site. Unable to talk or speak, the resident's left arm was moving up and down. On 12/20/17 at 1:00 PM, Res #7 still had a lot of secretions coming out of his mouth. No staff had gone in to suction him or check on him. Then at 1:02 PM, two staff were seen entering the room to suction and care for the resident. That afternoon at 1:29 PM, the resident was again observed with large saliva bubbles forming at and around his mouth and his chin and neck	4 115	For R7 suctioning was provided upon notification. The care plan was updated to reflect the resident's current orders. Other residents with orders for suctioning have the potential to be affected by this practice. The orders for those residents will be reviewed and education was provided for staff members responsible for suctioning. Suctioning policies and procedures will be reviewed and revised if appropriate.	1/30/18

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4 115	Continued From page 9 area were wet again with the secretions. The resident was kept home from school this day due to brace fitting by a local hospital. Review of the December 2017 Physician's Order Sheet (POS) found the resident was to have his trach tube suctioned as needed to clear secretions. The resident's care plan: At Risk for Ineffective breathing and airway r/t (related to) mucus plug and tracheostomy/ventilator dependent stated to maintain a patent airway at all times, suction as ordered and as needed via nasal, oral and tracheal routes. The resident's care plan also had not been updated since August 2017. During an interview with Staff #119, she stated the resident was to be suctioned as per the orders and care plan, but this was not being done. The facility failed to provide quality and safe care to the resident in a dignified manner. 2) On 12/19/17 at 09:31 AM, observed R#18 at the facility's onsite school. The resident was lying supine on a table with Staff#24 massaging his/her extremities. When Staff#24 was queried on what she was doing, she replied she was performing range of motion (ROM) exercises on R#18's extremities. Christmas music was playing on a computer tablet, but Staff#24 did not speak to R#18 while performing ROM on the resident. On 12/21/17 at 10:49 AM observed R#18 in the activity area being positioned in a stander by Staff#79. Staff#88 came to talk to R#18 and stated that resident used to smile and laugh more but changed from a year ago. Queried Staff#88 whether change in R#18 due to new staff and she replied that after experiencing more seizures his countenance changed. Staff#79 then started to	4 115	For R18 the school employees were educated on communicating with residents while providing range of motion assistance. The care plan was updated to reflect the resident's communication plan. The employee caring for R18 was counseled on providing cares with privacy and comfort. Other residents who receive range of motion assistance and who receive ADL assistance have the potential to be affected by this practice.	2/12/18

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4 115	Continued From page 10 wipe R#18's face and stated that she was doing resident's facial massage. Staff#79 was more attuned to the task at hand and only said a few words to the resident, e.g., "Ok, relax your face." On 12/22/17 at 07:25 AM observed Staff#117 providing a bed bath to R#18. Upon entering through the privacy curtains, surveyor observed that R#18 was naked on the bed with damp skin and visibly shaking his arms and legs. Staff#117 was removing a tub of water from the bed and queried if R#18 is feeling cold. Staff#117 replied, "He's always like that," as she stepped away from the bed to get a towel. Staff#117 then covered R#18 with a towel and wiped the resident dry. When Staff#117 removed the towel to dress the resident, his hands were still visibly shaking. Staff#117 covered R#18 with a blanket after dressing him and went to turn on a fan that blew directly onto the resident. Queried Staff #117 why the fan was turned on and she replied that they always leave the fan on for the resident. The room was cool so surveyor and other staff had sweaters on. Staff#117 then decided to turn the fan off. On 12/22/17 at 03:37 PM, R#18's medical record review (MRR) found two care plans dated 6/11/17 for "Communication: cognition altered related to multi-congenital anomalies," and "Development altered related to: Developmental Delay." Care plans (CPs) Plan of Action included: "Assess ways resident attempts to communicate such as crying, laughing, smiling, touching, etc; Use touch as appropriate to communicate; Smile and speak calmly so as not to startle resident; Always tell resident what you are going to do with him; Use visual and tactile cues with resident; Talk to child with direct eye contact; Touch and stroke child during contact; Provide interactive	4 115		

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4 115	Continued From page 11 activities." 3) On 12/20/17 at 01:37 PM interviewed R#25's family member (FM) at the resident's bedside. The FM wanted to express feelings of frustration and annoyance on observations of nurses unfamiliar with R#25, that rush through care and not speak to the resident. "These new nurses just do their task, rush and R#25 starts to cry." The FM stated, "I know when R#25 is afraid of someone because she won't look at them and cries." She did not feel that the agency nurses became familiar with R#25 before providing care or that they were reliable. "The good doctor is gone. (R#25) senses and knows who she can trust by her body language." The FM reported her concerns to Staff#66, Staff#82 and Staff#61, "but no changes--still mostly agency nurses." On 12/27/17 at 02:52 PM, R#25's MRR found a CP dated 12/26/16, "Self care deficit related to quadriplegia and developmental delay;" with Goals: "to keep resident safe, clean and comfortable." The CP had "Reassessment date April 2017 >12/2017." Also noted in the "Interdisciplinary Progress Notes," dated 10/17/17 at 1800, was documentation of a meeting between the resident's FMs and the facility's licensed social worker (Staff #61). At this meeting the FMs voiced their concern and frustration about the care that was being provided to R#25. The plan after this meeting was for Staff #61 to speak with the facility's CEO to present their concerns and to request a meeting with the CEO on their behalf. Yet, there was no documentation in the MRR that this meeting with the CEO occurred or that the FM's concerns were fully addressed.	4 115	For R25 the care plan was updated to reflect resident's current problems, goals, and approaches. The staff members were educated on proper protocols for entering a resident's room. Other residents who require care and services in their rooms may have the potential to be affected by this practice.	1/2/18

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4 115	Continued From page 12 4) Observation of Resident #14 (R#14) revealed staff failed to care for her such as to maintain or enhance her quality of life, as this resident is unable to make her requests for assistance known. On 12/19/17 at 8:30 AM, two CNAs entered the resident's room talking with each other and did not announce or knock upon entering the room. This surveyor was in the room reviewing bedside records and the two staff were surprised to see surveyor in the room. Observation on 12/19/17 at 10:30 A.M., noted Staff #118 entered the room without any announcement. Observation on 12/20/17 at 8:00 AM, noted Staff #20 entered the room without any announcement too. Staff did not treat the resident with respect and dignity by failing to knock or announce themselves.	4 115	The Medical Director or designee will review the above policies and procedures and make recommendations as needed. Audits for suctioning, communication and privacy during provision of care, and asking for permission to enter after knocking will be completed weekly for 4 weeks, monthly for 3 months, and then as directed by the QAPI Committee after their review. The Director of Nursing or designee will be responsible for compliance.	2/12/18 & ongoing
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observations, record reviews, interviews and review of the facility's policies and procedures, the facility failed to ensure there was sufficient nursing staff with the appropriate competencies/skills sets to provide nursing and related services to ensure each resident received care that was safe, and able to maintain their highest practicable physical, mental, and	4 148		

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4 148	Continued From page 13 psychosocial well-being. It was found there was an insufficient number of licensed staff with a lack of competency training required to provide quality care for their residents who were all ventilatory dependent and required total care by staff. As a result, an immediate jeopardy (IJ) was identified for the systemic problems and potential for serious harm to occur to all their residents. Findings include: 1) On 12/19/17 at 08:25 AM, during the initial tour of the facility, surveyor observed Staff#42 and Staff#8 flushing R#24's peripherally inserted central catheter (PICC) line. Staff#42 was assisting Staff#8 who held 2 syringes filled with liquid, and asked, "Which syringe do I use first? Do I flush it with all (syringes)?" After the nurses completed the task, they were queried whether it took 2 nurses to flush R#24's PICC line. Staff#42 stated that she worked the night shift (NOC) and was supposed to have flushed R#24's PICC line but was too busy, so assisted the day shift nurse with the PICC line flush before going home because this resident was more complicated. Staff#42 further stated there were only 2 nurses working the night shift (NOC) and the day shift nurse had to work until 2300 to provide residents with trach care. The nurses reported that on 12/18/17 from 2300-0400 there were only 2 nurses on duty and a respiratory therapist on duty from 2100-0700. Staff#8 reported that since she started working with the facility as an agency nurse, 2 charge nurses have resigned and they were "short staffed." On 12/22/17 at 07:12 AM, observed Staff#120 flushing R#24's PICC line with 10 mls of normal	4 148	An IJ removal plan was submitted to the department and accepted on 12/22/17 at 1900. The plan included education and competencies on suctioning, medication administration, ventilator care, gastrostomy tube flushing, and tracheal suctioning. For R24 the PICC line was flushed upon notification. Other residents with a PICC line may have the potential to be affected by this practice. The policy and procedure for PICC lines and TPN were reviewed and revised as needed. Staff members responsible PICC lines and TPN were educated on following proper policies and procedures.	12/29/17

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4 148	Continued From page 14 saline, and then 0.4 mls of ethanol to lock the line, as the resident slept comfortably. Staff#120 said she was not sure who she was handing over care to for R#24, as her NOC shift ended. Staff#120 voiced concern over R#24's care as he was the only resident in the facility with a PICC line for which he received total parenteral nutrition (TPN). Staff#120 related on 12/18/17, she was the only permanent nurse staff on day shift and an agency nurse was assigned to R#24. The agency nurse was not familiar with R#24's care, and Staff#120 had to perform the dressing change to the resident's PICC line and guide the agency nurse to flush and start R#24's special TPN formula. The agency nurse also did not know how to start the portable TPN pump used in order for the resident to attend outside activities. Staff#120 said she could not understand why an agency nurse was assigned, who was not familiar with R#24 and had no orientation on his care. Staff#120 stated the DON made the nursing assignments, and that R#24 was the only one receiving TPN in the facility.	4 148		
	2) On 12/22/17 at 07:25 AM, observed Staff#117 providing a bed bath to R#18. Upon entering through the privacy curtains observed that R#18 was naked on the bed with damp skin and visibly shaking his arms and legs. Staff#117 was removing a tub of water from the bed and queried her whether R#18 was feeling cold. Staff#117 replied, "He's always like that," as she stepped away from the bed to get a towel. Staff#117 then covered R#18 with a towel and wiped the resident dry. When Staff#117 removed the towel to dress the resident, his hands were still visibly shaking. Staff#117 covered R#18 with a blanket after dressing him and went to turn on a fan that blew directly onto the resident. Queried Staff#117 why		For R18 the resident was provided with extra towels for privacy and comfort. Other residents who require bathing assistance have the potential to be affected by this practice. For R18 the bag changing schedule for tube feeding was reviewed and revised. Other residents with tube feeding have the potential to be affected by this practice. Staff members responsible for changing the bag were educated on the policy and procedure for tube feeding administration and maintenance.	12/29/17

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4 148	Continued From page 15 the fan was turned on and she replied that they always leave the fan on for the resident. The room was cool and surveyor and other staff had sweaters on. Staff#117 looked at surveyor, then decided to turn the fan off. After the bed bath, Staff#117 reconnected R#18's gastrostomy tube feeding (TF) and restarted the TF pump. The TF bag was dated 12/21/17; 0600; with 100 ml of formula in the bag. The TF pump was running at 40 ml/hr; volume delivered /dose limit read 736 mls. On 12/22/17 at 07:37 AM, queried Staff#119 about R#18's TF bag and when the formula was poured in. Staff#119 replied she did not know this facility's staff routine, but at other places the TF bags were changed at 12 midnight. The DON was not in and Staff#119 then asked the NOC shift nurse before she went home. The NOC shift nurse did not care for R#18 on her shift and had to ask another NOC shift nurse. Staff#119 then reported that the resident's formula was made and stored in the refrigerator and staff were to follow their feeding schedules and all residents had their TF bags changed at 0600, but sometimes it was done at 0800. On 12/22/17 at 07:49 AM, Staff#119 then went into R#18's room to turn off the feeding pump and stated, "Because we don't know." Staff #119 looked at R#18's MAR and found that the NOC shift nurse, Staff#19, administered the TF formula at 0600 on 12/22/17. Staff#119 stated this agency nurse probably used the 12/21/17 feeding bag instead of the new TF bag dated 12/22/17, that was also hanging on the TF pole, when she poured the 0600 TF formula. The NOC nurse used the wrong, outdated TF bag.	4 148		

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4 148	Continued From page 16 3) On 12/21/17 at 11:01 AM, observed Staff#72 administer Beneprotein powder to R#16. Staff#72 got a new container of Beneprotein, used a plastic spoon to get the scooper out, measured out 2 scoops of powder and placed the scooper back into container before closing it. The licensed staff did not know to remove the scooper and keep it out of the container to prevent contamination. 4) On 12/29/17 at 06:59 AM, interviewed Staff#8, an agency nurse, as to why R#16 had missing doses of meds. According to Staff#8, the meds were usually ordered by the charge nurse (CN) II position but currently all nurses were responsible. The med blister packs were delivered by the pharmacy and marked as 1 of 3 (1/3), 2/3, 3/3 (usually 3 blister packs for each med). "The nurse who opened the blister pack and marked 3/3 should order a refill from the pharmacy." She said previously it was the CN II's responsibility. Since 12/14/17 all the CN II positions have been vacant, and Staff#91 taught nursing staff how to order meds on 12/13/17. Staff#8 further stated that she received her nursing orientation on 10/29/17, and had experience in GT and trach care "but not vents." 5) During the course of the recertification survey, interviews were conducted with staff, administration and family members. Various individuals approached and asked this surveyor to speak with them on matters and concerns that were related to resident care in the facility: 5a) On 12/19/17 at 08:30 AM, interviewed staff #33 who stated, "All the RNs are agency except for one RN. Last night there were only two nurses. They mandated the three aides yesterday to stay. They always mandate. Last night one nurse from Kulana stayed back again	4 148	For R16 the scoop for the protein powder was removed upon notification. The can of protein powder was discarded and a new one opened for this resident. The policy and procedure for infection control and cross-contamination were reviewed and revised as needed. Other residents who have an order for protein powder may have the potential to be affected by this practice. Education was provided for staff members on infection control practices related to keeping medication containers free from contamination. Medications for R16 were reordered upon notification. Other residents who have orders for medication have the potential to be affected by this practice. Education will be provided on pharmacy orders and refills. The policy and procedure for medication administration will be reviewed and revised to reflect current standards of practice.	2/10/18

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4 148	Continued From page 17 because they were short...We work 12 hours, then we are mandated. Nowadays, people just pass when the call light goes on. I don't know what is going on. I've been here ten years and this is the worst that it has ever been." 5b) On 12/20/2017 at 10:30 AM, interviewed staff #118 who stated, "We have lost a lot of caring and conscientious nurses and aides too. Within the past year, the majority of people left because of management on the nursing side. We don't have any charge nurses anymore. We don't have a code nurse. If we have a code, the agency nurse may not be able to help, especially at night time...The patient workload for the nurses - alarms would be going off all the time. The nurses are going, going, going and no lunch. The nurses paid time off (PTO's) got denied and so they couldn't take any time off. My main concern is the safety. The norm is seven nurses. I know at one point, getting agency nurses increased our medical errors." 5c) On 12/19/17 at 11:25 AM, interviewed staff #20 who stated regarding her workload, "four (residents) is good. If anything else, I have to do like urinary tests, etc., then it becomes challenging." She stated, "I have seven residents--these four and two kids in the other room." 5d) On 12/20/17 at 09:20 AM, interviewed staff #39 who stated, "We are supposed to be five RNs and five CNAs. If you go below 25, the aides can go to four." Staff #66 is working on the floor today to make the five and assumes charge roles." This was confirmed on the nursing daily assignment sheet as well. 5e) On 12/20/17 R#25's family member (FM)	4 148	Numbers of sufficient staff were reviewed and bonuses were offered to staff members for picking up shifts and working overtime. Mandating policies were in place and the staff was aware of the policies. All residents have the potential to be affected by this practice. A staffing meeting will be held to review schedules, open shifts, recruitment, and retention practices. Direct care staff members will be included in the staffing meetings to gain insight on improving staffing. Roles and responsibilities of nursing and respiratory therapy will be defined and education will be provided to staff members. Audits for privacy, infection control, pharmacy ordering, medication administration, and staffing will be completed weekly for 4 weeks, monthly for three months, and as needed after review by the QAPI Committee if further recommendations are made. The Director of Nursing or designee will be responsible for compliance.	12/29/17 2/12/18 & ongoing 2/12/18 2/12/18 & ongoing

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4 148	Continued From page 18 requested to speak to this surveyor. Resident #25's FM stated, "I am worried about (R#25's) safety. I went by chain of command and I went up to the RNs and stated some of the issues. For example, they repeatedly will take the blood pressure on the same side of (R#25's) arm and not with just one person but others. They would leave her and others' bed rails down. If it's left down and they are doing other things, like turning around, she could fall because she is fast...I came every day, every night and every evening because they are short staffed and I'm worried. How do I know if she fell, how do I know if I'm not here? She holds onto me when somebody not good. She cries when someone is mistreating her. They are short staffed. Every night they are short staffed. When I need help, there is no charge nurse. I have to stand around and look for someone. A lot of times, the roommate's trach collar is off and the other families don't come and these kids cannot call for themselves. (R#25) has butt rash because of neglect and she has had dodo (poop) in her diaper that needs to be cleaned. Why did all these nurses leave here? The RNs here are doing a lot. Two nights ago, I asked the nurse to help clean my daughter up but she said she could not because she had ten patients and we are short staffed. Later on, someone told her to do it. I brought it to the director of nursing and administrator but they said 'there are changes and there have been bad apples'. I brought it to the owner and he told me that staffing when they leave because they have more experience and they move on but others stay because they live close by. I asked him how come he cannot hold on to the oldies and the newbies. People are rushing to get things done here...My main concern is that they lack safety protocol, and management training. I feel if I vocalize, I feel there will be retaliation. I feel like	4 148		

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4 148	Continued From page 19 they know because the way they look at me and the way communication has changed. They don't wash their hands and come and take care of my daughter. I talked to the administrator and asked to talk with the doctor and she said I cannot talk with the doctor and she said to talk with the director of nursing because she has all the answers. The last time I talked to him when he told me that she is losing weight and it is good for her body--it was September". 5f) On 12/20/17 at 01:49 PM, observation was made at the nursing station where a monitor at the nursing station displays oxygen saturation and pulse. It was observed that the alarms were sounding for 20 minutes and this surveyor did not see any nurse, management or ward clerk address this. Queried Staff #32 regarding who looked at the alarms and she stated, "I do or any immediate nurse or I go to the director of nursing." Queried Staff #110 who stated, "I am not trained for the monitors, mostly the CNAs and nurses. If it's red, I call somebody for a sound. There is no unit clerk at night and at night we don't have a charge nurse. The charge nurse would usually help everyone here and monitor the screen too. But, not enough nurses, mostly agencies...Worked here almost 8 years. Sometimes I help them answer the call light and there's no one to answer because they don't have enough staff. When there is a delivery, I go to the back too." Observation on 12/20/17 at 03:00 PM revealed a red alarm with a heart rate that went down to 39 beats per minute and an oxygen saturation level of 91%. Staff #32 was sitting at the nurses station and did not show an urgency for a "red alarm". 5g) On 12/21/17 at 07:50 AM, interviewed staff #34. She said, "Because of what is going on, I	4 148		

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4 148	Continued From page 20 decided to work the minimum. I feel that with the whole staffing issues, my license is on the line. Last night was four staff, me and the other nurse--had a total of 9 patients. There was no charge nurse and the last charge nurse left. The night shift, we don't have support for anyone to come in if one of us is sick. If there was a storm to come, I don't know where the back up generator is. I know that the management is back up but I don't feel that they are there for us. I feel like the patient safety and care is being compromised. For instance, repositioning, especially when the aides are short and changing them when they (residents) are soiled. Trach care and catheter care is compromised. There are times when we were short and the management has said not to do the trach care...With the new agency staff coming in, they don't know the patients like we do and the agency nurse actually passed one of her narcotics which was scheduled for 10:00 P.M. at midnight (two hours late). Because there is no charge nurse, there is no one to oversee. With the agency nurses, their expectations are probably higher than what it actually is. For instance, the agency nurse did a straight cath into the chucks. The agency nurses are asking their aide's to do the work instead of them doing it. There are a lot of med passes. If there is a med pass error, who is accountable for it? For example missing the dose or doubling the dose and this happens mainly because we are short staffed". 5h) On 12/22/17 at 07:45 AM, interviewed Staff #120 who stated, "I have worked here for four years. The other night, there were only two nurses. I was supposed to get off at 7:30 PM and I stayed to 11:30 PM. I was mandated. Two nurses were new and I was the third person. I stayed to do care and pass meds. We only had	4 148		

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4 148	Continued From page 21 three nurses for 25 from 11:30 pm to 7:00 am. There was only two for 25 and I don't think the agency carried a load. It's been like this for one year, staffing has been an issue. Easter there was just two. We told management we cannot accept this. Management told us that we can accept the assignment or we can leave but suffer consequences. Management said to focus on the care, airway, meds, feeding. Although we have a respiratory therapist, suctioning gets pushed to the side. The things that would not get done is the trach care, G-tube care and urinary catheter care. I am able to get my care done but I am rushed. The agency nurses are not able to get everything done or they don't know how to do it. The charge nurses were slowly leaving and they weren't replaced. I put my name down and I never got trained. I'm leaving because it is too unsafe and I may come in and I may have the whole building to myself. Last night, there were four of us, then one nurse was sick and she went home. That left us with three nurse. There is two of us that have nine patients and the other one has seven". 5i) Interview with Staff #88 on 12/29/17 at 08:36 AM revealed that, "The family had asked staff to take R#14 out on shower days and there were six aides and they didn't bring her out". Staff #88 stated that "it's because we have agency aides and they don't bring the adult residents out of their rooms". Cross-reference to findings at F656. 5j) The SA also confirmed the RN staffing based on these interviews to the nursing daily assignment sheets from 12/20/17 and found it to be accurate to what the staff were reporting. Although the 12/18/17 staffing assignment was requested by a surveyor, it was not produced.	4 148		

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4 148	Continued From page 22 However, Staff #66 affirmed during an interview on 12/22/17 that, "we are still having problems with staffing" and she worked that night shift when they only had 2 RNs for their 25 residents. 6) During the observation of Res #1 on 12/21/17 at 9:12 AM, Staff #98 stated the nurse aides usually are assigned to care for five residents each. "Only when we get 7 or 9, it's very hard. Yesterday we had 7 each, because 1 CNA called out. Since recent, because people leave, we're getting help from agency, but we have a lot of staff turnover. You just feel overburdened and and tired, and can't take your break on time and extra exhausted and then they (administration) will mandate you, like when they only have 3 CNAs at night. They mandate you to stay until 11:30 PM if they are short on night CNAs. And then when you are working 12 hours, you feel so exhausted already and have to work extra. Yes, I feel that way. I will tell my charge nurse--but now we don't no more (have a charge nurse). Now I have to call (DON) to talk to her. I think the first time I was mandated, I told her I worked 2 days straight and mandated to stay over and then working the next day, so for me to work I'm not going to be able to focus and they should get somebody else." She said they are currently using 2 or 3 agency CNAs at this time as well and she is training Staff #15. 7) Interview with Staff #82 on 12/22/17 at 12:39 PM confirmed their nurse staffing had been affected by a large number of staff who resigned within the past several months. On 12/27/17, Staff #82 also produced the first printout of their payroll based journal (PBJ). She acknowledged the difference of 3,575.75 staff hours from the previous quarter ending 9/30/17 compared to the one ending 12/27/17. Cross-reference to findings	4 148		

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4 148	Continued From page 23 at F838 and F851. 8) On 12/22/17 at 8:16 AM, interview of Staff #34 was done. Staff #34 said a couple of months ago, the nurse staffing ratio to resident care was either 7, 8 or 9 residents to a nurse, and the census was more than 25. Staff #34 believed due to poor care, some residents had to be sent to the hospital such as Res #28. With the current census at 25, Staff #34 did not feel like the residents were receiving the proper care they deserved such as checking the residents hourly, "especially when they are hypotensive and bradycardic." Staff #34 said the respiratory therapists (RTs) come in at 10:00 AM and they do the ventilator checks every 4 hours. "The new nurses and the agency nurses don't know what to do about the vent settings, and you have to check it on the log. Some of the new hires are more task oriented, so they surpass that because 'it's the RTs job', but it's not the RTs job. I feel the CNAs should have vent competency too, but it hasn't been scheduled by the DON." For medication administration, Staff #34 said she was trained by two nurses no longer at the facility. She was taught to put two tablets into separate medication cups to crush. Staff #34 said the water flushes for the medications were only given before and after the administration. She said, "No annual competency check that I know of." Staff #34 said the agency nurses were trained on 3 night shifts and 3 day shifts. "The recent ones have experience, but the first ones, like (Staff #16), had no experience." 9) On 12/22/17 at 8:50 AM, interview of Staff #119 was done. Staff #119 said she told Staff #66 of the medication (med) errors that "there were a lot of them, this is a lot of errors. so the	4 148		

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4 148	Continued From page 24 ones making errors, they had to re-read." Staff #119 stated the med errors had to do with a dot system and symbols. If the nurse put a med into a med cup, they would put a dot on it. But she said some would give it, or they would forget, or they gave a double dose, "and they don't count how much meds." Staff #119 said, "old nurses say its the new ones doing this, but something is wrong with the system. They're not doing it right, they sign the MARs (Medication Administration Record) late, and they making their own symbols." Staff #119 said the orientation for new nurses is 3 days of training. Staff #119 stated she recognized the "procrastination in every area." For the medication errors, she told the administration they will have to answer to it because they were not keeping track of it. She also said the night shift staffing on 12/21/17--"everyone called in sick and I told (DON) if you don't have a staff member coming in, then you have to come. You're getting rid of these people but you also gotta train them." Staff #119 further confirmed the nurses were not having their skills competency checked with their orientation. 10) On 12/22/17 at 10:10 AM, interview of Staff #65 was done. Staff #65 stated it has been escalating to the point where he has asked the night shift RTs to do their first rounds at 10 pm by checking airway clearance, do assessments and complete any night treatments. "By morning, we prepare the children for school and told them (RTs) to mainly concentrate on if these residents are being suctioned--that's the most important thing, because if they let them settle into their secretions, you don't want it to settle into their lungs."	4 148		

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4 148	Continued From page 25 Staff #65 was asked about the licensed nurse's role in conjunction with the respiratory therapists. He replied, "It's more frequent with the agency nurses. The therapists asked me about it too, and we're not picking on them, but they seem to be overwhelmed with their work and they think that tracheal suctioning is like second priority. We notice they seem to be overwhelmed with passing meds." Staff #65 stated as a result, the nurses will rely on the RTs to suction because they are behind on passing medications. Staff #65 was asked who did the ventilator training competencies, and replied, "The turnover has been so fast and furious we cannot keep up with who has done it and who didn't do it yet. I approached (DON) about vent competency and to give me an hour or so, but she can't even pull them off the floors. I don't think the agency is done because I don't remember doing any of them. When they (new hires) first come on, we do the suctioning with them, and if find they're not doing it competently, like there's tracheal bleeding due to trauma, we identify that nurse who shouldn't be doing it until we do their competency again and we deem them competent." Staff #65 stated as for the health and safety of the residents at this time, "it's like something is going to happen--I hope not, but it's just when. You cannot depend on luck." 11) On 12/22/17 at 3:35 PM, interview of Staff #72 was done. She stated they were all hired on as a charge nurse. She said she was not trained as a charge nurse however, and questioned how could fulfill this duty if they were not trained for it. Staff #72 said, "We're always short (staffed). I did Tuesday night, 7pm to 7am, but didn't leave then." She stated because they are constantly short of staff, they are mandated to stay. She	4 148	For the residents of Kulana Malama, the staff members responsible for nursing management and direct care will be educated on nursing competencies. Each staff member will have evidence of competency training the following areas: Ventilator care and services, medication administration, tracheostomy suctioning, tracking of medication errors, agency orientation and competencies, gastrostomy flushing, medication administration for G and J Tube residents, crushing medications, and application of a Bair Hugger. All residents have the potential to be affected by this practice. Audits on staff competencies will be completed monthly for three months and as needed to ensure all staff has the proper training and education. The results of the audits will be reported to the QAPI Committee and recommendations made if needed. The Director of Nursing or designee will be responsible for compliance.	2/12/18 2/12/18 & ongoing

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4 148	Continued From page 26 had seven residents to care for during her day shift today including orienting a new nurse. "So you just juggle, and our load is normally like 7 or 8 (residents) and when they hire, they tell you it's 6. The DON has ultimately the end say. It's just frustrating. We haven't had a monthly nursing meeting forever, and now two more long term staff are leaving." She stated she did not know where their current nursing policies and procedures were but that another agency nurse had asked her about it as well. Staff #72 said, for tonight's shift, one scheduled RN "called in sick, so the 7-7 (night shift) will only have 3 RNs. They're probably going to mandate one of us to stay back or the DON will have to."	4 148		
4 175	11-94.1-43(c) Interdisciplinary care process (c) The overall plan of care shall be reviewed periodically by the interdisciplinary team to determine if goals have been met, if any changes are required to the overall plan of care, and as necessitated by changes in the resident's condition. This Statute is not met as evidenced by: Based on observations, medical record reviews (MRR) and staff interviews the facility failed to establish a comprehensive care plan, document and implement the care and services to be provided, and if goals have been met, that changes were made to the overall plan of care necessitated by changes in the resident's condition for 5 of 16 residents (Res #25, #14, #1, #7 and #23), to assist each resident in attaining or maintaining his or her highest practicable quality of life.	4 175		

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4 175	Continued From page 27 Findings include: 1) On 12/27/17 at 03:14 PM, the MRR on R#25 noted on a speech language pathologist (SLP) evaluation report dated 11/19/17, the resident was assessed with oral dysphagia and suspected /possible pharyngeal dysphagia. The dysphagia note addendum documented that R#25 was seen for communication and dysphagia treatment. It was also reported that the family was found feeding yogurt to R#25, "despite repeated warnings not to engage in oral trials without presence of Rehab." Issues and concerns were discussed with the nurse practitioner (NP) and nursing staff. The importance of balancing safe feeding trials with decreasing oral aversion was discussed at length with the family and they provided return demonstration techniques. The plan was for the family to demonstrate positive eating models in front of R#25 and have the resident feed them too, in order to encourage positive feeding experiences. The family agreed to the plan and nursing was informed. On the SLP evaluation dated 11/28/17, the resident was assessed to have oral dysphagia and suspected/possible pharyngeal dysphagia; characterized by significant oral aversion, minimal oral intake, poor lip seal, poor bolus manipulation, and oral motor coordination deficits for feeding. The functional summary documented that R#25 was still demonstrating oral aversion by turning away from food presentations. The resident's oral intake was minimal and they were working towards increasing intake so a modified barium swallow study (MBSS) could be done. On 12/05/17 the SLP documented in a SOAP note, ...A: "R#25 continues to present with delays in communication & feeding...Feeding - continues	4 175	For R25 a new assessment was completed for oral feeding opportunities, oral aversion, and food play. The care plan was reviewed and revised to address physical, mental, and psychosocial needs. Other residents who are candidates for weaning from a vent have the potential to be affected by this practice.	1/31/18

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4 175	Continued From page 28 oral aversion. Took only one bite volitionally, all other intakes by swipes to mouth. P: Continue to work on increasing intake; Continue to work towards MBSS." The Care Plan Conference Summary dated 12/12/17, documented, "Discharge Planning: Parents unable to provide care at this time, inadequate housing, currently trying to find housing. Interdisciplinary Team Follow-up: Resp: Currently remains on vent at rest, will continue to assess and wean as able...Nursing: working on G-tube feeds, trach care, suctioning...Activities: Using developmental play; plan for field trip end of December/Jan 2018...CNA: Has all her current". On 12/29/17 at 09:25 AM interview of Staff#30 found that R#25 was scheduled for surgery in Feb 2018 to "close soft palate." According to Staff#30, food play was not working for R#25, as resident did not want anything near her mouth, and demonstrated oral aversion. Staff#30 further stated that was typical for residents with a trach/vent to have oral aversion due to not used to placing things in their mouths. Queried Staff#30 on R#25's comprehensive CP to address oral aversion and food play. Staff#30 stated that R#25 has been here only for a year and usually early intervention services (EIS) is in place that consists of an OT, PT, SLP who develops a comprehensive CP. She said EIS usually alerts the resident's primary care physician (PCP) for changes to the CP for food play and/or oral aversion. Staff#30 stated that she requested the MBSS to ensure R#25 was not aspirating through her trach, but R#25 unable to swallow enough barium	4 175		

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4 175	Continued From page 29 to do the test. Staff#30 also cound not find a CP for the resident's oral aversion and food play, and stated, "I don't do the CPs." The resident was evaluated by EIS on 1/24/17; and under "Suggested Activities and Strategies: Provide safe, pleasant experiences for oral care and play; Make sure she is in a stable seated position for better head and trunk control; Make sure she is not exhibiting upper airway congestion/ wet vocal quality before starting; Provide variety of safe teethers/toys for name to explore; If providing input to her then grade it in a comfortable manner when approaching her face/mouth; You can add singing or providing the input at a comfortable rhythm on your approach." The facility did not develop and implement a person-centered comprehensive care plan to meet R#25's goals for oral feeding, and address the resident's medical, physical, mental and psychosocial needs. 2) R#14 is a 34 year old quadriplegic resident with encephalitis who is dependent on the nursing staff for all activities and care. It was observed by this surveyor, that R#14 did not participate in the activities in the "common area" for the duration of the survey. Record review (RR) for R#14 showed the activity schedule log mainly consisted of stimulation from the TV and music played in her room. RR on 12/28/17 revealed an activity quarterly progress note on R#14 stating, "She participates in activities daily in the common area or 1:1 room visits." The adult activity attendance log showed the resident participated the majority of the time watching TV/movies in her room. Further record review revealed no comprehensive care plan for activities.	4 175	For R14 the care plan will be reviewed and revised to reflect the resident's goals for activities. Education will be provided for the staff members on who is responsible for writing and updating care plans and that all staff members are responsible for transporting residents to activities outside their rooms. All residents have the potential to be affected by this practice. All activity care plans will be reviewed to assess compliance with following the plan of care. Audits for activity participation will be completed weekly for four weeks, monthly for three months, and as needed per the recommendations of the QAPI Committee after review. The Activity Director or designee will be responsible for compliance.	2/12/18 2/12/18 & ongoing

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4 175	Continued From page 30 Interview with Staff #88 was done on 12/29/17 at 08:36 AM. She stated, "The family had asked staff to take R#14 out on shower days and there were six aides and they didn't bring her out. It's because we have agency aides and they don't bring the adult residents out of their rooms". She further stated that R#14's family's preference was for R#14 to be in the common area after she gets cleaned up as tolerated. "A lot of people don't come out because the nurses didn't do trach care. The nurses prefer we wait for them to do trach care before bringing them out but then they don't get to trach care until change of the shift. We do standing therapy, it's for physical therapy. We are only budgeted for two people. We can't even do our regular people with our budget. So much staff left and now we have 95% agency. We have 8 standers (residents who use a standing device). The nurses are supposed to do trach care, G tube, feeding, meds. Activities does tracking, massage, visual, sometimes we help with diaper change." Interview with Staff #61 on 12/29/17 confirmed that the family preference was for R#14 to engage in the common area activities. 12/29/17 at 08:58 AM, interview with Staff #92 was done. She said, "We base our program from orders from physical therapy. This is based off family preferences. Before, (R#14) was able to make her needs known but we still do the same activities. I believe that the (family member) requested highlights and a professional came and did haircuts and highlights for her. Her family also requested her to come outside as well. The CNAs are responsible for them to come outside to participate with activities. If they don't come out then we bring the activities to them".	4 175		

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4 175	Continued From page 31 The facility did not develop and implement a person-centered comprehensive care plan to meet R#14's goals for activities, the family's preferences and failed to address the resident's medical, physical, mental and psychosocial needs. 3) Also for R#14, it was found she had a history of frequent urinary tract infections (UTIs). Record review (RR) on 12/21/17 at 09:31 AM revealed that R#14 was admitted with an indwelling catheter because of a neurogenic bladder. R#14 has had frequent UTIs. Lab tests were done for diagnosis of a UTI on 7/4/17. On 9/7/17, R#14 had an episode of hematuria during the night and her physician was aware. On 10/02/17 a urine sample with reflex to culture and sensitivity (C&S) was done and a diagnosis of UTI was made. Per the progress notes, R#14 had a temp of 39 degrees centigrade and "continues with foul odor urine. Urine draining concentrated dark yellow urine with large amount of sediments and foul odor". On 11/8/17 another urine sample with reflex to C&S was done. Her urine sample again revealed a UTI. Then on 12/18/17 another urine sample with reflex to C&S revealed another diagnosis of UTI. RR dated 12/12/17 at 11:00 A.M. showed a physician's order for cranberry juice 60 mls to be given four times a day (to prevent UTI). However, the medication administration review (MAR) found the resident did not receive this order 18 times over an 18 day span because it was "not available". On 12/21/17 at 9:55 AM, Staff#72 stated, "I don't know about the care plans but they do interdisciplinary plan of corrections. She does have sediments in her urine". RR on 12/21/17 of	4 175	For R14 the care plan was reviewed and revised to reflect current problems, goals, and approaches. Dietary ordering and par levels were reviewed to ensure food and drink is available per diet and other orders	1/18/18

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4 175	Continued From page 32 the interdisciplinary care team meeting notes on 11/14/17 did not document R#14's treatment or care for her repeated UTIs. Further review of the resident's care plans on 12/21/17 did not mention the order for cranberry juice administration for her UTI. On 12/22/17 interview of Staff#120 was done. She stated, "We only had three nurses for 25 residents from 11:30 to 7:00 a.m. The other night we had only two nurses. She was queried regarding how this affected resident care and she said, "Staffing has been an issue. We have been told to focus on the care of airway, meds and feeding. The things that would not get done is the trach care, G-tube care and urinary catheter care. The agency nurses are not able to get everything done or they don't know how to do it. Administration told us to prioritize our care this way." 4) On 12/21/17 at 9:06 AM, Res #1 was observed in bed connected to the ventilator. Staff #15 stated the resident's "heart rate is going down a bit," looked around and then left the room. The Masimo set monitor found the resident's oxygen saturation at 98%, but his heart rate was between 46 to 51 beats per minute (bpm) per a six minute observation period. The resident had his eyes open and was blinking, but could not verbalize anything. At 9:12 AM, Staff #98 came into the room with Staff #15 and placed an additional blanket on the resident. Staff #15 was asked when she noticed the resident "bradying down" (staff were using this term as a drop in the heart rate), and she stated it was around 9:00 AM when she changed the resident's shirt. Staff #15 also said the	4 175	For R1, R23, and R7 the care plans were reviewed and revised to reflect current problems, goals, and approaches. All other care plans were reviewed and revised to ensure they are up to date and followed. Education was provided to staff members on the proper timing and revisions of care plans. The facility policy and procedure for comprehensive care plans will be reviewed and revised to reflect current standards of practice. Audits will be completed on care plans weekly for four weeks, monthly for three months, and as needed upon recommendations from the QAPI Committee after review. The Director of Nursing or designee will be responsible for compliance.	2/12/18 2/12/18 & ongoing

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4 175	Continued From page 33 blankets had been pulled off of him. Staff #98 stated the resident's usual heart rate was around 65 bpm and took his temperature at 97.2 degrees Fahrenheit (F). Staff #98 said she had a pager and notified the nurse to let her know "he's bradying down more." Staff #98 said with four blankets he should be okay. The licensed staff attending to the resident did not come in to assess him during this time. There was a Bair Hugger next to the beside but it was not being used for this resident. On 12/22/17 at 7:56 AM, the resident's O2 sat was at 99%, and his heart rate was between 47 and 49 bpm. He only had one blanket on. His assigned nurse aide and licensed nurse were not in the immediate area. On 12/27/17 at 12:19 PM, during an interview with Staff #98, she said Staff #15 was an agency staff whom she was training about what can happen "when the resident's shirt is taken off." Staff #98 confirmed she informed the nurse on 12/21/17 but was told she was busy passing medications. She also said they put the Bair Hugger on the resident if his temperature went below 96 degrees F, and, "if his heart rate is low, that means he is cold. Or I'll try and keep his head warm." Staff #98 said she was involved in Res #1's care plan and knew about the use of the Bair Hugger, "but we (aides) do a lot more to be honest. If the nurse is extra busy and we're short staffed, they would ask us to put the Bair Hugger. The nurse is supposed to put it on--it's the nurse duties. Not the CNAs." She stated for the nurse assigned to the resident, "you just keep reminding them." On 12/27/17 at 2:52 PM, interview of Staff #66 was done. She stated a clarification she recently	4 175		

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	125057	A. BUILDING: _____ B. WING _____	12/29/2017

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4 175	Continued From page 34 heard was to check Res #1's temperature and it was not to be based on "the low heart rates." Staff #66 also nodded in agreement the resident's care plan had not been updated to include what the nurse aides were doing, i.e., putting on the blankets, recent clarification of temperature checks, ensure licensed staff assess the resident if he is bradycardic (Staff #98 said, "when he's cold, and his heart rate will start dropping, although his temp 97.2"), and, who/when to apply the Bair Hugger with clear monitoring parameters. Staff #66 concurred the current vital signs log was inconsistent with missing information, of which should include those interventions being implemented as part of Res #1's care plan. Staff #66 said she and her licensed staff were responsible for updating the care plan. Staff #66 also confirmed for Res #1, 14 of his care plans had not updated/reassessed since March 2017 and one care plan since May of 2016. This was a total of 15 plans of care for Res #1 not reviewed/revised. 5) For Resident #23, he had one care plan for nutrition which had a "To Date" of 5/23/17. Five other care plans had a last reassessment date of "08/17" and two care plans developed on 5/28/17 had no follow-up review or reassessment dates. 6) For Resident #7, his two care plans were last reassessed in "8/2017". On 12/27/17 at 2:50 PM, Staff #66 verified the overall care plans for their residents had not been updated. On 12/21/17 at 3:05 PM, Staff #66 also acknowledged the facility's policy and procedure on Comprehensive Care Plans, "this too (their policy), hasn't been updated."	4 175		

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4 184	Continued From page 35	4 184		
4 184	11-94.1-46(a) Pharmaceutical services (a) Each facility shall employ a licensed pharmacist, or shall have a written contractual arrangement with a licensed pharmacist, to provide consultation on methods and procedures for ordering, storing, administering, disposing, and recordkeeping of drugs and biologicals, and provisions for emergency service. This Statute is not met as evidenced by:	4 184		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented.	4 185		

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4 185	Continued From page 36 This Statute is not met as evidenced by: Based on observations, record reviews, interviews and review of the facility's policy and procedure, the facility failed to ensure that its residents are free of any significant medication errors for 4 of 16 residents (Residents #25, #14, #16, and #23) in the survey sample. As a result, there was a failure to protect from potential adverse medication consequences, a failure to have concise physician's orders for the crushing of medications administered via the G-tubes and flushing protocols, and a failure to ensure interventions were implemented for the identified pattern of repeated medication errors, including the identification of licensed staff who may have required additional training. In addition, it was found there were insufficient numbers of licensed staff who lacked the training for medication administration to adequately provide safe, competent nursing care for these residents who were all ventilatory dependent and required total care by staff. Further, the facility's practice of medication administration was not based on current standards of practice as evidenced by the actions observed of the licensed staff and others who were interviewed. As a result, there existed a high potential for harm to the health and safety of all their residents and an immediate jeopardy (IJ) was identified on 12/22/17. Findings includes: 1) On 12/22/17 at 12:39 PM, the SA met with Staff #82, #66, #65 and #119. The facility staff was informed of the IJ based on the SA's medication error rate at 92%. Staff #119 stated she recognized the "flushing of the medications" was an issue, and it was not being done when the nurses were passing their medications to the	4 185		

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4 185	Continued From page 37 residents. Staff #119 said this is the standard protocol to follow but that their previous medical director did not think it was necessary. She stated the administrative staff were all aware of this practice of not flushing between medications and it has been taught this way. Staff #119 concurred the standard of practice was to also ensure crushed medications administered via the G-tube were not to be given all mixed together. The SA observed during the medication administration observation of various licensed staff that they were also drawing up random amounts of distilled water to dilute the combined medications. There were no resident specific orders to crush all the medications, nor orders to mix all the medications together, nor how much water to mix or dilute the medications with, and/or what the specific flush amounts were between the medications. The facility had 20 pediatric residents and 5 adult residents, however, there were no specific, individualized orders based on each resident's medical history and condition. 2) During an interview with the consultant pharmacist on 12/27/17 at 9:29 AM, she said they mostly have residents on fluid restriction in this facility. She was asked whether she observed the nurses performing medication administration at this facility, and she said no. Thus, when she was informed by the SA how the nurses were observed randomly drawing up free amounts of distilled water to dilute all of their crushed medications together, that if their residents were on fluid restriction, it would make it worse (fluid overload with no parameters). She then stated, "we will need to tighten it up." The consultant pharmacist also said her recommendation was to get a physician's order,	4 185	For R25, R16, and R23 the flushes in between medications were implemented upon notification. The physician orders for R25 were reviewed and the staff members were educated on the proper protocol for crushing and flushing medications and for following physician orders. For R16 an order was obtained for crushing medications. Other residents with orders for crushing and flushing medications have the potential to be affected by this practice. Medication error tracking was brought up to date upon notification. Education on the system for tracking medication errors was provided for nursing management. Staff members responsible for medication administration will be educated on the proper procedure for administering medications via G or J Tube. Observation audits will be completed on medication administration for tubes weekly for four weeks, monthly for three months, and then as needed to ensure compliance. The results will be reported to the QAPI Committee for further review and recommendations. The Director of Nursing or designee will be responsible for compliance.	12/29/17 2/12/18 2/12/18 & ongoing

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4 185	Continued From page 38 but she had not enforced it because her pharmaceutical company's policies "are getting revised." She said it was to be available in December and thought they would have a policy in time. She acknowledged their policies and procedures were yet to be revised although she was aware of the Phase 2 implementation of the federal regulations for long term care facilities. 3) Staff #82 verified the policies and procedures had not been reviewed/revised by the end of the extended survey. Staff #82 stated, "No, in all honesty, no," as her response. She had been discussing it with their interim medical director and re-did the abuse type policy as well as creating a binder for the administrative policies. She confirmed the facility's existing policies and procedures have not been reviewed/revised for a long time. (Staff #66 had confirmed it was last done in 2012). Staff #82 also stated there was a loss of their regular licensed staff with the largest exit of staff "starting around 4-6 weeks ago." She said these were the nurses who were at the facility 7-9 years, and currently, there was almost no licensed staff with this many years of experience. She also stated their facility assessment "is going to the QA committee." 4) The facility's IJ abatement plan was accepted on 12/22/17 at 7:00 PM. It included the facility's corrective measures for 1) medication administration which a review of their current policy and procedure and and all resident orders to be reviewed. This included immediate training/orientation starting with shift huddles on the evening of 12/22/17. The plan included the crushing of individual pills to mix with 5 ml of distilled water to dissolve it, flushing the G-tube and/or J-tube with 5 ml of distilled water before giving the med, followed with a 1 ml flush of	4 185	An IJ removal plan was submitted to the department and accepted on 12/22/17 at 1900. The plan included education and competencies on suctioning, medication administration, ventilator care, gastrostomy tube flushing, and tracheal suctioning. A meeting was held with the pharmacy personnel to determine proper standards of practice related to unavailable or missing medications. All residents have the potential to be affected by this practice. Education on the system for tracking medication errors was provided for nursing management. Staff members responsible for medication administration will be educated on the proper procedure for administering medications via G or J Tube. Observation audits will be completed on medication administration for tubes weekly for four weeks, monthly for three months, and then as needed to ensure compliance. The results will be reported to the QAPI Committee for further review and recommendations. The Director of Nursing or designee will be responsible for compliance.	12/29/17 2/12/18 2/12/18 & ongoing

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4 185	Continued From page 39 distilled water between each medication, unless ordered differently, and after giving the medication to follow with 5 ml of distilled water flush. It also included staff competency reviews at the start of each shift to ensure all staff were signed off for G-tube flushing (licensed nurses and CNAs) and medication administration for G-tube and J-tube (licensed staff only). It was revealed during the observations and interviews of many staff, that licensed staff were learning how to administer medications based on who previously taught them, and were not following clear physician/NP orders or have updated and current policies and procedures to follow.	4 185		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on observations, record reviews, interviews and review of the facility's policies and procedures, the facility failed to ensure its infection prevention and control program (IPCP) included a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and, failed to ensure the use of an updated system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	4 203	It is the policy of Kulana Malama to implement established infection control practices. This includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. An Infection Control Preventionist has been assigned and will receive education on the new and revised regulations for infection control practices. All staff members will receive education on their roles and responsibilities as it	2/12/18

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4 203	Continued From page 40 Finding includes: On 12/27/17 at 1:55 PM, interview with Staff #66 was done. She stated she is the assigned infection preventionist (IP) for the facility. She stated the criteria she has includes new forms (McGeer criteria) which their consultant IP provided to her, "but the new forms has to pass through QA." Staff #66 confirmed she was not using the McGeer criteria forms and "it's a work in progress." She stated she does random observation surveillance of the facility to identify any breaches in infection control. When Staff #66 was queried if she documented the any "misses" related to such, she stated, "I usually do a verbal and then if it happens again, will do a note to file." She also stated she sends her surveillance to the consultant who reviews and numbers and the report. She the past leadership preferred not to work with her and the former medical director was to have guided her, "but it didn't happen so starting Jan 2017, I had to make the call to switch gears and I started to work with (consultant IC) more." Staff #66 also said there were no cultures being done because the former medical director "didn't really do cultures, but the nurse practitioner is of the mindset to do them." Staff #66 was queried about the facility's August 2017 respiratory tract infection (RTI) rate of 11, compared to 6 RTIs in May, 2 RTIs in June and and 1 in September 2017. She was asked about this higher RTI number for tracheitis and said they did things such as daily reminders and staff huddles to ensure they are doing proper care. When she was asked if she did observations as the tracheitis rate in September decreased to 1 case, she said she could not pinpoint this change, except that in August some of the residents went back to school. Staff #66 said she would send	4 203	pertains to infection prevention and control. The calculations for infection rates will be revised to include the correct formulas for calculation. Proper infection control guidelines will be implemented and reports made to the QAPI Committee on identification, tracking, and control of infections. Audits will be completed weekly for four weeks, monthly for three months, and as needed to ensure compliance. The QAPI Committee will make recommendations as needed based on the results of the audits. All residents have the potential to be affected by this practice. The Director of Nursing or designee will be responsible for compliance.	2/12/18 & ongoing

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4 203	Continued From page 41 her monthly surveillance reports to their consultant IP and recently received clarification that the consultant will have access to lab results as well. Staff #66 stated for their next coming QA meeting, they "will be looking at who we want on the ASP team. Before the ADON, we were going to have me and (Staff #30) do it." On 12/28/17 at 7:47 AM, interview of Staff #65 revealed there was a prior system that tracked the facility's infection rates for pneumonia, tracheitis and other respiratory infections. The data showed trends from 2011-2016, but after that, there was no data that tracked these events/incidences. Per Staff #65, he stopped receiving this data and said it was tracked per 1000 "vent" days or "cumulative trach and vent" days as an example, and they also identified the actual pediatric and/or adult resident as delineated on the diagrams. Staff #65 believed this system was effective and allowed differentiation, such that as an example, "some of it is, or can be exacerbation of bronchietasis, and too, if it's not the vent, it's the disease." On 12/29/17, Staff #82 stated she is in touch with an organization to see how their benchmarking surveys will compare to this facility. Although the facility began utilizing an outside IP consultant, the data tracking for 2017 did not demonstrate how for potentially high risk areas, given that all of their residents are on trach/ventilatory support, did not show how the RTIs were being analyzed using a data driven tracking method. The previous system delineated the pneumonia and tracheitis rates with a further breakdown between vent and trach	4 203	An antibiotic stewardship program will be implemented based on the new and revised regulations. The program will be the responsibility of the Infection Preventionist. Education will be provided to staff members on their roles, responsibilities and documentation requirements for antibiotic stewardship. Reports on antibiotic stewardship will be reviewed by the QAPI Committee. The Medical Director and pharmacy consultant will assist the facility in identifying patterns of unnecessary treatment and antibiotic usage. Audits on antibiotics will be completed weekly for four weeks, monthly for four months and as needed to ensure compliance. The results of the audits will be brought to the QAPI Committee for further recommendations as needed. The Director of Nursing or designee will be responsible for compliance.	2/12/18 & ongoing

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4 203	Continued From page 42 days and between the adult and pediatric population on ventilatory use. This was not evidenced in the May to September 2017 reports. The IP consultant also documented, "The facility did not provide the total residents day information for May-Sept. This report can be completed once consultant receives this information." Staff #66 stated this has not been done and she also had not sent the resident care plans which the IP consultant also requested. On 12/28/17 at 12:30 PM, Staff #82 acknowledged that for an antibiotic stewardship program (ASP) to develop, they would have to track the pediatric and adult rates and not how the current IP report is done. On 12/29/17 at 11:22 AM, Staff #119 said the ASP "never went to QA but it should have." Staff #119 stated there also was "no project selected" for the ASP and they are not monitoring the use of antibiotics as a result.	4 203		
4 263	11-94.1-65(c)(4) Construction requirements (c) The facility shall ensure resident accessibility to living and service areas: (4) All occupants of any bedroom shall be of the same sex except for those semi-private rooms that may be occupied by married couples or long-time non-married couples upon request. This Statute is not met as evidenced by: Based on interview and observation, the facility did not ensure all occupants of any bedroom shall be of the same sex.	4 263		

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4 263	Continued From page 43 Finding includes: During the entrance interview on 12/19/17 with Staff #82, she requested the on-going waiver for mixed gender and age as the residents in two rooms, room 14 and room 13 had residents of mixed gender. All of these residents are tracheostomy and ventilatory dependent residents and could not speak. They also required total assistance from staff for their care. Staff #82 presented a 12/20/17 letter formally requesting the continuation of this waiver as part of their re-licensure. The facility's letter was reviewed on-site and ensured that the health, safety, or welfare the resident(s) would not be compromised.	4 263	A request was submitted to the State of Hawaii, Department of Health, Office of Health Care Assurance concerning an extension to the waiver for Chapter 94.1, Section 11-94.1-65(c)(4). When there is a chance for residents of the opposite sex to be placed together the Social Services Director speaks to the family/legal guardian for the residents who reside in the potential room, informing them of the potential and addressing any concerns which may be raised.	2/12/18